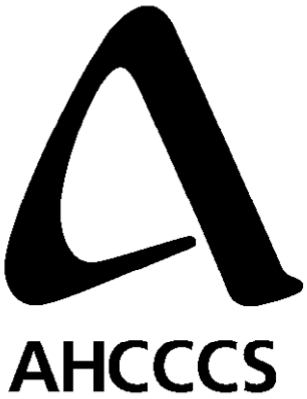
# Chapter 4

# Fee-for-Service General Billing Rules



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## OVERVIEW

This chapter contains general information related to AHCCCS Fee-for-Service billing rules and requirements. Policies regarding submission and processing of Fee-for-Service claims are outlined in later sections of this *AHCCCS Fee-for-Service Provider Manual*. Additional information is distributed quarterly via *Claims Clues*.

Claims must meet AHCCCS requirements for claims submission. In the absence of specific policies, AHCCCS endeavors to follow Medicare policy guidelines as closely as possible.

In addition to Medicare requirements, AHCCCS follows the coding standards described in the *UB-92 Manual; International Classification of Diseases, 9th Revision (ICD-9) Manual;* current editions of the *Physicians' Current Procedural Terminology (CPT) Manual* and *HCFA Common Procedure Coding System (HCPCS) Manual;* as well as the *First Data Bank Blue Book* for pharmacy information.

## CLAIM FORM SUBMISSION REQUIREMENTS

Claims for services must:

- ☑ Be legible Claims that are not legible will be returned to the provider without processing. If a claim is returned, the provider must re-file a legible copy of the claim on the correct type of claim form and submit it within the appropriate time frame.

- ☑ Be submitted on the correct form for the type of service billed. Claims that are not submitted on the correct form will be returned to the provider without processing. If a claim is returned, the provider must re-file a legible copy of the claim on the correct type of claim form and submit it within the appropriate time frame.

- ☑ Not contain highlighter or color marks. AHCCCS retains a permanent electronic image of all paper claims submitted. Claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") may not be used. Permanent self-adhesive correction tape must be used to cover information that should not appear on the claim.

### Claim Documentation Submission Requirements

Any documentation submitted with a claim or subsequent to the submission of a claim is imaged and linked to the claim image. Documentation is not required when resubmitting claims if the required documentation was submitted with an earlier version of the claim.

All claims should be mailed to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

The provider is responsible for delivery of claims to AHCCCS, including the provision of adequate postage.

**HIPAA-compliant 837 Electronic Claim Submission**

AHCCCS accepts HIPAA-compliant 837 electronic claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837 transactions.

For more information, contact the AHCCCS Electronic Claims Submission Unit at (602) 417-4892 or (602) 417-4706.

**CLAIM SUBMISSION TIME FRAMES**

In accordance with ARS §36-2904 (G), claims for services provided to an AHCCCS recipient must be received by AHCCCS in a timely manner.

☑ Fee-for-Service claims are considered timely submissions if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of service, except for retro-eligibility claims. For hospital inpatient claims, “date of service” means the date of discharge of the patient.

☑ Claims initially received beyond the 6-month time frame, except retro-eligibility claims, will be denied

☑ If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim is a retro-eligibility claim.

☑ If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

☑ This time limit does not apply to adjustments, which would decrease the original AHCCCS payment due to collections from Medicare or other third party payers.

Note: As defined by ARS §36-2904 (G)(1) a "clean claim" is:

> A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

## RETRO-ELIGIBILITY CLAIMS

A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

- ☑ Retro-eligibility Fee-for-Service claims are considered timely submissions if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting.
- ☑ Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.
- ☑ Adjustments to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.
- ☑ This time limit does not apply to adjustments, which would decrease the original AHCCCS payment due to collections from Medicare or other third party payers.

## BILLING AHCCCS RECIPIENTS

Arizona Revised Statute §36-2903.01(N) prohibits providers from billing AHCCCS eligible? recipients, including QMB (defined?) Only recipients, for AHCCCS-covered services:

> Upon oral or written notice from the patient that the patient believes the claims to be covered by the system [AHCCCS], a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:
>
> 1. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
> 2. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care or

services unless specifically authorized by this article or rules adopted pursuant to this article.

**RESUBMISSIONS, ADJUSTMENTS, AND VOIDS**

Resubmissions

The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process.

- ☑ These errors will be reported to the provider on the AHCCCS Remittance Advice.
- ☑ Providers should correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim time frame (See Chapter 26, Correcting Claim Errors, and Chapter 27, Understanding the Remittance Advice).
- ☑ When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines.
- ☑ The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.

Providers do *not* need to resubmit documentation unless specifically requested to do so.

☑ To resubmit a denied CMS 1500 claim:

- ✓ Enter “A” in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim in the field labeled "Original Ref. No."
- ✓ Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.
  - ☒ Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

  Example:

  Provider submits a three-line claim. Lines 1 and 3 are paid, but Line 2 is denied.

  When resubmitting the claim, the provider should resubmit all three lines. If only Line 2 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 3.

☑ To resubmit a denied UB-92 claim:

- ✓ Write the word “Resubmission” and the CRN of the denied claim in the “Remarks” field (Field 84).

- ☒ If Field 84 is used for other purposes, write the word “Resubmission” and the CRN at the top of the claim form.

☑ To resubmit a denied ADA 2002 claim:

- ✓ Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

Adjustments

After a claim has been paid by AHCCCS, errors may be discovered in the amounts or services that were billed. These errors may require submission of an adjustment to the paid claim. For example, a provider may discover that additional services should be billed for a service span or that incorrect charges were entered on a claim paid by AHCCCS.

When adjusting a paid claim, the provider must:

- ✓ Submit a new claim containing all previously submitted lines.
- ✓ If any previously paid lines are blanked out, the AHCCCS system will assume that those lines should not be considered for reimbursement, and payment will be recouped.
- ✓ The original CRN must be included on the claim to enable the AHCCCS system to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Every field can be changed on the adjusted claim except the service and billing provider ID number and tax ID number. If these must be changed, the claim must be voided and a new claim submitted.

☑ To adjust a paid CMS 1500 claim:

- ✓ Enter “A” in Field 22 and the CRN of the claim to be adjusted in the field labeled "Original Ref. No."
- ✓ Resubmit the claim in its entirety, including all original lines.
  - ☒ Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

  Example:

  Provider submits a three-line claim to AHCCCS. All three lines are paid.

  The provider discovers an error in the number of units billed on Line 3 and submits an adjustment.

When submitting the adjustment, the provider should resubmit all three lines. If only Line 3 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 2.

- ✓ An adjustment for additional charges to a paid claim must include all charges -- the original billed charges plus additional charges.

  Example:

  A provider bills for two units of a service with a unit charge of $50.00 and is reimbursed $100.00. After receiving payment, the provider discovers that three units of the service should have been billed.

  When adjusting the claim, the provider should bill for three units and total billed charges of $150.00 (3 units X $50.00/unit). The AHCCCS system will pay the claim as follows:

  | | |
  |---|---|
  | Allowed Amount (3 units) | $150.00 |
  | Previously Paid to Provider | <$100.00> |
  | Reimbursement | $ 50.00 |

  If the provider billed for the one additional unit at $50.00, the AHCCCS system would recoup $50.00 as shown below:

  | | |
  |---|---|
  | Allowed Amount (1 unit) | $50.00 |
  | Previously Paid to Provider | <$100.00> |
  | Reimbursement (Amount recouped) | <$ 50.00> |

**RESUBMISSIONS, ADJUSTMENTS, AND VOIDS (CONT.)**

☑ To adjust a paid UB-92 claim:

- ✓ Write the word "Adjustment" and the CRN of the claim to be adjusted in the "Remarks" field (Field 84).
  - ☒ If Field 84 is used for other purposes, write the word "Adjustment" and CRN at the top of the claim form.

☑ To adjust a paid ADA 2002 claim:

- ✓ Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

Voids

When voiding a claim, the provider should:

- ✓ Submit documentation stating the reason for the void.
- ✓ Only the provider who submitted the original claim may void the claim.
- ✓ When a claim is voided, all payment is recouped.
- ✓ This process should only be used when there is no other alternative.
- ✓ Unlike resubmissions and adjustments, providers should submit only the line(s) to be voided. Lines that should be not be voided should be blanked out to avoid recoupment of payment for those lines.

☑ To void a CMS 1500 claim:

- ✓ Enter "V" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

☑ To void a UB-92 claim:

- ✓ Use bill type XX7 (for example 117, 727, etc.) and enter the CRN of the claim to be voided in the "Remarks" field (Field 84).
  - ☒ If Field 84 is used for other purposes, write the CRN at the top of the claim form.

☑ To void a paid ADA 2002 claim:

- ✓ Write the word "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

**OVERPAYMENTS**

A provider must notify AHCCCS of an overpayment on a claim.

- ✓ The must submit an adjustment to the paid claim. (See Pages 4-4 through 4-6 for instructions on submitting an adjustment.)
- ✓ Providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.
- ✓ The claim will appear in the Adjusted Claims section of the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount. (See Chapter 27, Understanding the Remittance Advice)

**GENERAL AHCCCS BILLING RULES—**

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS.

☑ Billing span

- ✓ Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

☑ Billing multiple units

- ✓ If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form.
- ✓ The units field is used to specify the number of times the procedure was performed on the date of service.
- ✓ The total billed charge is the unit charge multiplied by the number of units.

☑ Medicare and third party payments

- ✓ By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.
- ✓ Providers must determine the extent of third party coverage and bill all third party payers prior to billing AHCCCS.

**NOTE:** See Chapter 9, Medicare/Other Insurance Liability.

**GENERAL AHCCCS BILLING RULES (CONT.)**

☑ Age, gender, and frequency based service limitations

- ✓ AHCCCS imposes some limitations on services based on recipient age and/or gender.
- ✓ Some procedures have a limit on the number of units that can be provided to a recipient during a given time span.
- ✓ The AHCCCS Office of Special Programs may revise these limits as appropriate.

☑ Emergency services claims

- ✓ All claims are considered non-emergent and subject to applicable prior authorization and Indian Health Service referral requirements unless the provider clearly identifies the service billed on the claim form as an emergency.
  - ☒ If a recipient is eligible for emergency services only and if no PA was obtained as required, the claim will be denied if the service is not identified as an emergency.
- ✓ On the UB-92 claim form, the Admit Type (Field 19) must be "1" (emergency) or "4" (newborn) on all emergency inpatient and outpatient claims.
  - ☒ All other Admit Types, including a "2" for urgent, designate the claim as non-emergent.
- ✓ On the CMS 1500 claim form, Field 24I must be marked to indicate that the service billed on a particular claim line was an emergency.
- ✓ AHCCCS staff will review ADA 2002 dental claims for adults to determine if the service provided was emergent.
  - ☒ Adults are eligible for emergency dental services only.

☑ Recoupment

- ✓ Under certain circumstances, AHCCCS may find it necessary to *recoup* or take back money previously paid to a provider.
- ✓ Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.
- ✓ Upon completion of the recoupment, AHCCCS will send a letter explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.
- ✓ If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), the provider will be afforded additional time to provide justification for re-payment.

**GENERAL AHCCCS BILLING RULES (CONT.)**

☑ Recoupment (Cont.)

- ✓ If a copy of the recoupment letter and the claim are submitted within the stipulated time period, AHCCCS will override time edits.
  - ☒ If the claim is submitted without a copy of the letter, AHCCCS will not override time edits, and the claim will be denied.
- ✓ In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.
- ✓ The time span allowed for submission of a clean claim will be the *greatest* of:
  - ☒ Twelve months from the date of service, or
  - ☒ Twelve months from the date of eligibility posting for a retro-eligibility claim, or
  - ☒ Sixty days from the date of the recoupment letter.
- ✓ If recoupment is initiated by the AHCCCS Office of Program Integrity as a result of identified misrepresentation, the provider will not be afforded additional time to resubmit a clean claim.

☑ Double-sided copies of claims

- ✓ Providers cannot submit double-sided multiple-page claims.
- ✓ Each claim page must be on a separate piece of paper.
- ✓ Claim pages should be numbered (e.g., 1 of 3, 2 of 3, 3 of 3).

☑ Multiple-page UB-92 claims

- ✓ To ensure that all pages of a multiple-page UB-92 claim are processed as a single claim:
  - ☒ Claim pages should be numbered (e.g., 1 of 3, 2 of 3, 3 of 3).
  - ☒ All pages should be clipped together in the upper left-hand corner (Do not staple).
  - ☒ If documentation is too thick to clip, clip claim pages and rubber band documentation to the claim.
  - ☒ Totals should not be carried forward onto each page.
  - ☒ The "001" total should be entered on the last page only.

**GENERAL AHCCCS BILLING RULES (CONT.)**

☑ Zero charges

- ✓ AHCCCS will key revenue and procedure codes billed with zero charges.
- ✓ However, revenue codes with zero charges will not be considered for reimbursement.

☑ Provider ID changes

- ✓ When a provider ID changes or a facility is sold, rights to payment may not be immediately clear.
- ✓ To avoid delays and possible payment errors, separate bills should be submitted for the periods before and after the change in the provider's ID number.

☑ Mothers and newborns

- ✓ Newborns whose mothers are AHCCCS recipients are eligible for AHCCCS services from the time of delivery.
- ✓ Newborns receive separate AHCCCS identification numbers, and services for a newborn must be billed separately using the newborn's AHCCCS ID.
  - ☒ Services for the newborn that are included on the mother's claim will be denied.
- ✓ Contact the AHCCCS Verification Unit for newborn eligibility and enrollment information (See Chapter 2, Recipient Eligibility and Enrollment).

☑ Change in recipient eligibility/enrollment

- ✓ If the recipient is ineligible for any portion of the service span, those periods should not be billed to AHCCCS.
- ✓ If a recipient's eligibility changes, each eligible period should be billed separately to avoid processing delays.

☑ Change in reimbursement rate

- ✓ It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.
  - ☒ Reimbursement of inpatient claims is based on the rate in effect on the admission date.
- ✓ When a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rate, the claim must be split.

## GENERAL AHCCCS BILLING RULES (CONT.)

☑ Negotiated payments

- ✓ In some cases, providers negotiate special payment provisions for services delivered during a specific period of time.
- ✓ Because processing of claims can be affected by these agreements, claims for service spans that overlap a negotiated payment span should be split to avoid denial or delay of payment.

☑ Inappropriate hospital split bills

- ✓ It is inappropriate to split the following inpatient hospital claims:
  - ☒ The day of discharge cannot be split from the rest of the inpatient stay and billed as a same day admission/discharge.
  - ☒ The day of discharge cannot be split from the rest of the inpatient stay if it is the first day of AHCCCS eligibility for the recipient.
  - ☒ Emergency room claims cannot be split from an inpatient stay. Emergency room charges are included in the tier per diem reimbursement.

## DOCUMENTATION REQUIREMENTS

Medical review is a function of the AHCCCS Claims Department and is performed to determine if services were provided according to AHCCCS policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided

In order for this medical review to take place, providers may be asked to submit additional documentation for fee-for-Service CMS 1500 claims identified in the AHCCCS claims processing system as near duplicate claims. The documentation is necessary to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, same day, same recipient, and different providers.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, Medical Review staff will release the claim for payment, assuming that the claim has not failed any other edits.

**GENERAL AHCCCS BILLING RULES (CONT.)**

If no medical documentation is submitted, Medical Review staff will deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with Medical Review denial code "MD008 - Resubmit with progress notes." Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 99291 (Critical care, evaluation and management) and 99231-99233 (Subsequent hospital care) will frequently fail the near duplicate edit because it is feasible that a recipient could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill AHCCCS for CPT Code 99291 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the Medical Review nurse will deny the claim with denial code "MD008 - Resubmit with progress notes."

## DOCUMENTATION REQUIREMENTS (CONT.)

While it is impossible to offer specific guidelines for each situation, the table below is designed to give providers some general guidance regarding submission of documentation. ~~Also~~, not all Fee-for-Service claims submitted to AHCCCS are subject to Medical Review.

| CMS 1500 Claims | | |
|---|---|---|
| **Billing For** | **Documents Required** | **Comments** |
| Surgical procedures | History and physical, operative report | |
| Missed abortion/ Incomplete abortion<br><br>Procedures (all CPT codes ) | History and physical, ultrasound report, operative report, pathology report | Information must substantiate fetal demise. |
| Emergency room visits | Emergency room record | Billing physician's signature must be on ER record |
| Anesthesia | Anesthesia records | Include begin and end time |
| Pathology | Pathology reports | |
| E&M services | Progress notes, History and physical, office records, discharge summary, consult reports | Documentation should be specific to code billed |
| Radiology | X-ray/Scan reports | |
| Medical procedures | Procedure report, history and physical | Examples: Cardiac catheterizations, Doppler studies, etc. |
| **UB-92 Claims** | | |
| **Billing for** | **Documents Required** | **Comments** |
| Observation | All documents required by statute and observation records | If labor and delivery, send labor and delivery records |
| Missed abortion/Incomplete abortion | All documents required by statute, ultrasound report, operative report, pathology report | Information must substantiate fetal demise |
| NICU/ICU tier claims | All documents required by statute | MD orders and MD progress notes to substantiate level of care billed |
| Outlier | All documents required by statute | |

## DOCUMENTATION REQUIREMENTS (CONT.)

Providers should *not* submit the following documentation unless specifically requested to do so:

- ☑ Emergency admission authorization forms
- ☑ Patient follow-up care instructions
- ☑ Nurses notes
- ☑ Blank medical documentation forms
- ☑ Consents for treatment forms
- ☑ Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- ☑ Ultrasound/X-ray films
- ☑ Medifax information
- ☑ Nursing care plans
- ☑ Medication administration records (MAR)
- ☑ DRG/Coding forms
- ☑ Medical documentation on prior authorized procedures/hospital stays
- ☑ Entire medical records